STATE OF COLORADO Fitness-To-Return Certification

Instructions to Employee: Sign the release on the other side. Return to your agency before or on the day you return to work.
Instructions to Employing Agency: Attach the task statements from the official Position Description Questionnaire. This completed form is to be placed in a separate, confidential medical file with limited access.
Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work.

Employee's Name	Employee ID Number:

1. **Date** the condition began.

2(a) Check one of the following.

- ☐ The employee is able to work a full, regularly scheduled day with no restrictions beginning _____ (date).
- ☐ The employee is unable to return for any work until _____ (date).
- ☐ The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date).
- ☐ The employee is able to return to work with restrictions from _____ (date) through (date). Please complete next section (b).

(b) Please indicate restrictions.

- ☐ no lifting or carrying objects: _____ max. lbs. Repetitions
- ☐ no pushing/pulling objects: _____ max. lbs. Repetitions
- ☐ no bending/stooping/squatting/twisting: Repetitions
- ☐ no kneeling for more than _____ hours each day
- ☐ no crawling for more than _____ hours each day
- ☐ no sitting for more than _____ hours each day
- ☐ no standing for more than _____ hours each day
- ☐ no walking for more than _____ hours each day
- ☐ no climbing stairs
- ☐ no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than _____ hours each day
- ☐ no reaching above the head or shoulders
- ☐ no reaching away from the body greater than _____ with Γ right Γ left arm
- ☐ no grasping objects with Γ right Γ left hand
- ☐ no fine manipulation with Γ right Γ left hand
- ☐ no assaultive, physical control, and/or arrest situations
- ☐ no driving a vehicle
- ☐ no operating machinery or equipment
- ☐ no working alone
- ☐ no use of firearms
- ☐ no typing, keyboarding, or entering data for more than _____ hours each day
- ☐ no use of a CRT or computer monitor for more than _____ hours each day
- ☐ no use, including repetitive, of _____ (extremity/joint)
- ☐ no weight bearing on _____ (extremity)
- ☐ Other restrictions (specify):

3. Other Instructions:

Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Health Care Provider Signature | Date

Printed Name | Type of Practice

Address | Phone

Medical Release

I authorize the release of any medical information necessary to complete this form. Knowingly providing false information directly, or through another party, may result in adverse action.

Employee's Signature | Date